Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST ALPHONSUS REGIONAL MEDICAL
CENTER
PO BOX 190930
BOISE ID 83719

Respondent Name

TEXAS MUNICIPAL LEAGUE

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-07-4828-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above named patient was treated at this facility on November 29, 2006. The total charges incurred were $3068.25. When the insurance carrier finally paid this claim, they only paid $858.66. This is well below the Idaho Fee Schedule. It is understood that the clai is based in Texas, however, most other out of state workers compensation companies will pay at the Idaho Fee Schedule. I have enclosed a copy of the Provisions surrounding payment for your review… A 'reasonable' charge means it does not exceed the providers 'usual' and 'customary' charge. We attest that that actual charges on this account are our USUAL charges, and therefore would be charged the same for all payors. The payment received is incorrect. Please sanction Texas Municipal League to pay the balances that have been reduced for usual and customary reasons."

Amount in Dispute: $2712.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges that since they are located Idaho, they are entitled to reimbursement in accordance with the Idaho Workers' Compensation laws. This is not correct. The provider treated a Texas Workers' Compensation patient and is only entitled to the reimbursement owed under Texas Workers' Compensation laws. The Provider has been correctly paid, in accordance with the Texas Labor Code and Texas Administrative Code. Provider is not entitled to additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson, PO Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 29. 2006	Outpatient Surgery	$2,712.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Under what authority is a request for medical fee dispute resolution considered?
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W10 – Payment fair and reasonable methodology.
   - 211 50% of Reasonable & Customary Charge.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Findings

1. The requestor provided surgical services in the state of Idaho on November 29, 2006 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(A), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all medical bill(s)… as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).
5. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
6. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of

reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "A 'reasonable' charge means it does not exceed the providers 'usual' and 'customary' charge. We attest that the actual charges on this account are our USUAL charges, therefore would be charged the same for all payors."
- The requestor did not submit documentation to support that it billed it's usual and customary.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 9, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.